

IMMACULATE CONCEPTION SCHOOL
2011 CROSS-COUNTRY

Physical/Immunization Form

Player's Name: _____ Date of Birth: _____

The above patient was examined on _____.
The patient's healthy history and immunization records were reviewed.

Height: _____ Weight: _____ Blood Pressure: _____

Vision: Left _____ Right _____ Color _____ Postural Screen _____

Allergies: _____

Chronic Medical Problems: _____

Medications/Treatments: _____

Dietary Restrictions: _____

I SEE NO REASON(S) TO RESTRICT FULL PARTICIPATION IN IMMACULATE
CONCEPTION ACTIVITIES.

Physician's name (Printed): _____ Phone #: _____

Physician's Signature: _____ Date: _____

PARENTS: I CERTIFY THAT MY CHILD HAS NOT INCURRED ANY
SIGNIFICANT HEALTH PROBLEM(S) SINCE THE DATE OF THE ABOVE
PHYSICAL EXAM.

IN CASE OF EMERGENCY, I AUTHORIZE COACHES TO TRANSPORT MY
CHILD TO THE CLOSEST MEDICAL FACILITY IN MY ABSENCE.

Parent's Signature: _____ Date: _____

PLEASE ATTACH YOUR CHILD'S IMMUNIZATION RECORD.